The Department of Defense Pharmacoeconomic Center *PEC Update*

November/December 2002, Vol. 03, Issue 2, www.pec.ha.osd.mil

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Drugs for Donuts: the Second Time Around

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- How rationalizations stand up to research (not particularly well)
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Plus, amusing quotes about advertising!

***relatively speaking**

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2003 DoD Pharmacoeconomic & Pharmacy Benefit Conference

The 2003 DoD Pharmacoeconomics & Pharmacy Benefit Conference will be held January 12 - 15, 2003, at the St. Anthony Hotel in San Antonio, Texas. The theme is "Measuring the Clinical Outcomes of Drug Therapy." An agenda & registration form are available on the PEC website.

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New Drug Watch

7 new drugs approved, 6 new OTCs or generics, 5 new indications, 4 new guidelines, 3 new precautions, 2 metformin combos, & a home defibribillator!*
Includes LT Chad McKenzie's article on guaifenesin extended release!

***To be sung to the tune of "The Twelve Days of Christmas"**

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Excellent Quote of the Month

"After a few weeks here, you will ... hopefully leave your PEC voo-doo doll in your desk drawer after the next BCF change or closed-class contract decision!

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PEC Update Information

Subscribing

Would you like to receive the e-mail newsletter direct to your Inbox? Let us know by e-mailing Carol Scott, the PEC secretary, at carol.scott@amedd.army.mil.

Editors' E-mails

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Submitting Articles

Do you have an article you'd like to see published in the *PEC Update*? Just send CAPT Torkildson or Shana Trice an e-mail, or call the PEC at DSN 421-1271, Commercial (210)

PDTS Corner

Update on the Pharmacy Data Transaction Service

- **PDTS Receives Honors for Enhancing Patient Safety** - **The Pharmacy Data Transaction Service (PDTS) was honored at a 25 Nov 2002 ceremony in Washington, D.C., as one of seven finalists for the 2002 President's Quality Award, selected from among 100 applications. PDTS has also been selected as one of 17 results-driven federal government programs to be a semifinalist for Harvard's prestigious Innovations in American Government Award. The 17 programs are among 99 semifinalists selected from a pool of nearly 1,000 applicants. Fifteen of the 99 semifinalists will be named as finalists.**

- **The CSSC at Combined Forces - COL (Ret) Roger Williams, PDTS CSSC Clinical Support Supervisor, thanks everyone for their interest in the PEC booth and the CSSC's Business Objects Demo, and modestly fails to mention his poster, "PDTS: A Vital Tenet in DoD Pharmacy's Support of Patient Safety, Readiness and Homeland Defense," which won the "Poster Best Representing Conference Theme" award at Combined Forces.**

- **Top 10 Level 1 Drug-Drug Interactions for September 2002 by Point of Service**

Special Note: Did you know RxNET has...Subscriptions?

- **This feature allows users to receive a digest of all new posts made to a particular forum in the last 24 hours. Just go to EDIT PROFILE on the top menu bar on any page within RxNet and select SUBSCRIPTIONS. For each forum you designate, you will receive an morning e-mail listing of new posts made to that forum. You can change your subscriptions at any time.**

- **Remember, replying is as easy as clicking the link in the e-mail—this will take you right back to the message on RxNet so you can reply using the forum.**

- **Subscriptions is a great feature for those who don't frequent the site often but want to keep track of new messages. It can be helpful not just for forums specifically in your field of interest, but also for forums like "News and Alerts" and "Current P&T Discussions," which are designed to disseminate information and request feedback on items of broad interest.**

295-1271.

Publication Schedule

The *PEC Update* is published 10 times per year (monthly except July and December. On the grounds that no one is paying much attention those months, anyway...).

Our Disclaimer

The opinions expressed in this work are the views of the author(s), and do not necessarily reflect the views of the Department of Defense, the Army, Navy, Air Force, or the TRICARE Management Activity. Information presented in this work is meant for academic and educational purposes only. It is not intended nor should it be used as the definitive reference for the treatment or prophylaxis of various diseases. Use of specific product brand names are for identification purposes only unless otherwise indicated.

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EDITORIAL

Dare to Make a Difference

CAPT Joe Torkildson, MC, USN
Director, Clinical Operations Division
DoD Pharmacoeconomic Center

Editors' Letters

Please send your letters to the editors to Dr. Torkildson at Joseph.Torkildson@amedd.army.mil

In previous editorials I've mentioned the fact that I am currently enrolled in an Executive MBA program here at the University of Texas at San Antonio. In the beginning, I was a little nervous about getting back into the classroom after so many years. To be frank, I was a little concerned that the old adage "you can't teach an old dog new tricks" might actually be true. I have since discovered that I was right to be nervous; my mistake was in being nervous about not being able or willing to explore new ideas. What I should have been nervous about was how to react to the realization that the leadership curriculum would force me to ask myself some very hard questions about the sources of meaning and value in my life, and whether I was truly reflecting my values in my workplace. Since I'm typically not the sort who is willing to simply suffer in silence alone, and since in the Christian tradition Advent is a time of reflection and preparation, I decided to share some of the issues we are discussing and the questions we are raising with you so that my readers can share in both the discomfort and the joy of appreciative inquiry.

How do we know if we are living a meaningful life? I use a rather direct and simple yardstick to answer this question. In my mind, the answer comes at the end of the day, during that time when we're standing in the bathroom brushing our teeth and reflecting on the day's events. We simply ask ourselves at that moment "Is my world a better place this evening than it was this morning because I lived the day within it?" If the answer to that question truthfully is 'Yes' the majority of the time, then we're on the way. If the answer is often "Not really" or, God forbid, "No, actually I think it's a little worse off this evening than it was earlier," then we have some exploring to do. The basis of this exploration is grounded in some fascinating books that examine the tension between doing those things that leave us feeling personally fulfilled and those things that we do in order to pay the rent and support ourselves and our families. One of these, which I highly recommend, is Making a Life, Making a Living by Mark Albion. The premise of the book is that 1) we are so called to do something meaningful with our life that we can't help but be miserable if we don't answer that call; 2) it is possible to find an occupation that allows us to both make a life and make a living; 3) it is likely we will need to change what we do for a living in order to find that occupation; and 4) in order to do this we must first understand what ties us down to our current occupation.

Now, I have no problem with the first point of the premise; I think we've all met countless individuals (we may be one ourselves) who have complained about the lack of meaning in their jobs. I'll also buy the second point; I've actually met a few people who derive a tremendous amount of personal satisfaction from what they do for a living. I struggle a little with the third point, though. To me, suggesting that you can find meaning in your life if you just change jobs is like suggesting that you can find joy in your marriage if you just change spouses. I immediately begin to wonder whether the problem is truly with your job (spouse) or with your attitude. If it's the latter, you're likely going to be just as miserable in your next job (marriage) as you are now.

How can our attitude keep us from finding meaning in what we do for a living? First, we can live with the delusion that we can have two sets of values, the one we live at home and a different one that we live at the office. At home our life says, "Peace on earth, good will toward all" (since it's the Christmas season), while at work our life says, "I'd love to help you out, but we have a policy against doing the right thing." Second, we can convince ourselves that while we would like to live our values at the office, sometimes the cost is too great. We rationalize that if we just ignore the injustice this time in order to avoid irritating our boss, we'll do enough good stuff later on to even the score. Unfortunately, it's not until later that we realize that once we make this deal with the devil it only becomes easier to make it again and again. If we happen to be the boss, we can rationalize that we have an obligation to ensure that our subordinates, in their exuberance to do what's right, don't ignore all those essential rules, regulations and policies we've put in place for their own good. This is my personal favorite; I've actually heard senior leaders suggesting that this is perfectly appropriate. Unfortunately it's not until later that we realize that we've not only stifled our own innovation, we've subjected our subordinates to the same fate. This occurrence is doubly sad – not only does it undermine our own sense of value and that of our subordinates, it weakens the organization as well.

So how do we extract ourselves from this existence and create a situation where we bound out of bed every morning eager to get to work and spend the day feeling fulfilled? I submit that we first must be absolutely certain about what we believe in, what values we are committed to no matter what. Then, we have to figure out how those values are reflected in the vision of the organization in which we work. If they're not, then maybe we do have to find a new place in which to let our light shine. Fortunately, I think the number of Enrons out there is actually pretty small; most organizations at least pay lip service to positive values even if they have trouble creating an environment where they can be lived. We then have to figure out how we can be true to those values every day while we're on the job. It's not easy; sometimes we have to put ourselves in a position where we take some heat from someone above us who is not engaging in the same nightly inquiry that we are (and there are lots of those folks out there). In those cases, it is wise to first humbly inquire whether we are certain we are looking at the situation through the crystal clear lens of our value system. If the answer is yes, then it's decision time. We all make deals with the devil from time to time; the real issue is whether we stick with our values often enough that we can still recognize them when they come around the corner, or are reflected in the person standing in front of us at the window.

And most importantly, we have to believe with every essence of our being that our failure to live up to the principles we have established for ourselves is no one's fault but our own. Doing a half-baked job, failing to satisfy someone we are supposed to serve, going home early and leaving someone else to do our job – these are our decisions. They don't belong to our boss, or our spouse, or our co-worker; they are ours alone, just as surely as our success stories are.

So as we approach the end of the month, and start thinking about those New Year's resolutions that we're going to make and then break again this year, maybe we should take a different tack. Instead of deciding we're going to lose 5 pounds, or yell at our kids less, maybe we should instead commit to living a life that will allow us to smile at ourselves in the mirror a little more often at night and say, "Hey, you did really good today!" I predict that if it works, some of these other pesky little resolutions will take care of themselves.

I would like to take this opportunity to wish all my readers a blessed and happy holiday season. And if you find yourself wanting to grumble to me, "What does this have to do with pharmacy? my only answer is, "I have to look in the mirror tonight, too!"

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Contract Award for The TRICARE Mail Order Pharmacy (TMOP)

The TRICARE Management Activity recently announced the award for the next generation follow-on contract to the National Mail Order Pharmacy (NMOP) Program. The contract change affects many facets of the current NMOP Program, including the name, which will change to the TRICARE Mail Order Pharmacy (TMOP) Program. The TMOP contract was awarded to Express Scripts (ESI), a large prescription benefit management company with corporate offices in Maryland Height, Missouri. The contract has an effective date of 1 March 2003. The current NMOP contract with MedcoHealth has been extended through 28 February 2003.

While the new program will look and feel much like the NMOP to the beneficiary, numerous changes have been made to the infrastructure and program behind the scenes. Examples include:

- Contract administration moves from the Defense Supply Center Philadelphia (DSCP) to TMA-Aurora. Donald Kalil has been appointed as the Contracting Officer (CO), with Charles Brown as the Contracting Specialist . LTC Don De Groff, Director of the Pharmacy Benefit Operations division of the DoD Pharmacoeconomic Center (PEC) handles day-to-day operational oversight responsibilities as the Contracting Officer's Representative (COR). LTC De Groff is assisted by Lyn Bell (TMA-Aurora) as the Assistant Contracting Officer's Representative (ACOR). HM1 Lisa Drumm (PEC) is assigned as Administrative Assistant for the COR and ACOR.

- Mail dispensing and customer service will be located in a dedicated DoD facility located in Tempe, Arizona. The TMOP will order replenishment-only products from a DoD Prime Vendor, then receive and store those products in a dedicated area. After reconciliation, payment for the product will be made directly to the Prime Vendor by DoD.

- The Pharmacy Data Transaction Service (PDTS) will become the foundation upon which TMOP operates. ESI will connect to PDTS through a secure telecommunication network and will function much like a "retail" pharmacy does today, leaving eligibility, catastrophic cap, prospective drug utilization review (ProDUR), and plan design (e.g., quantity limits, days supply, prior authorization) the responsibility of PDTS.

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The dispensing fee for the NMOP has increased from $10.24 to $17.60 during the contract extension period. The dispensing fee for the TMOP award was $10.20.

For more information on TMOP operations watch for updates in the *PEC Update* and/or on the TRICARE website (**http://tricare.osd.mil**), presentations at the TRICARE Conference, as well as numerous public service announcements that will be forthcoming over the next several months. Beneficiaries currently using the NMOP will receive information about TMOP prior to its start date. Information will also be available on the Express-Scripts website: visit the TMOP press room at **http://www.express-scripts.com/custom/dod/pressroom.**

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The DoD Pharmacoeconomic Center – What is it, really??

Or, What I did on my November Rotation

LT Chad McKenzie, MSC, USN
(who should have finished his Pharm.D. at Idaho State University by the time you read this)

Junior officers – it's time to ask your command for a trip down to San Antonio to see what goes on at the PEC. You may be involved (or may have been involved in the past) with your local P&T committee, but you haven't seen anything until you've been here.

I think we've all had questions like "who on earth would ever devise such a horrible plan like mandatory switches to simvastatin?" (or rabeprazole, Precision QID – just substitute your favorite drug here). Well, here is your chance to discover the answer.

Working with the PEC staff, you will begin your journey down the yellow brick road in Business Objects training. After that, you will quickly gain fluency in your new language as you conduct data searches from PDTS, looking at cost and utilization of selected drugs, their use across the different points of service, how much they cost DoD, etc. You will see how interpreting these data can lead to formulary change strategies and contracting initiatives across DoD. No, Toto, we're not in Kansas anymore. Not only do you get to crunch the numbers, but you will also be searching for the latest and greatest (and also the not-so-greatest) literature on the drug or drug class in question, and determining which agent really is the best (or at least which one isn't as bad). So you think it's time to click your heels together and head home? No, not yet. The FDA just announced the approval of four new drugs – it's new monograph time!! Yes, you'll be spending the next few days obtaining product info from the manufacturer, looking for results from clinical trials that probably haven't been published yet (and may never be, for all we know), and making a recommendation to the DoD P&T Committee whether this is a good idea or not, how much it might cost, and what the consequences are of adding or not adding it to the BCF or NMOP.

After a few weeks here, you will certainly appreciate how much work goes into a DoD formulary decision, learn to make more evidence-based decisions at your own facility, and hopefully leave your PEC voo-doo doll in your desk drawer after the next BCF change or closed-class contract decision!


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Barb's Barbs

Drugs for Donuts: the Second Time Around

LtCol Barbara Roach, USAF, MC
Air Force Medical Officer, DoD Pharmacoeconomic Center

Is there any evidence that accepting a toy, dinner, or travel arrangement influences your prescribing practices? Well, first let's see what medical societies, the Services, and government agencies say about it.

What do medical societies say about accepting gifts, trips, etc from pharmaceutical companies?

From the American College of Physicians Ethics Manual are the following statements contained within the section entitled Financial Conflicts of Interest:

> "The acceptance of individual gifts, trips and subsidies of all types from the health care industry by an individual physician is strongly discouraged. The acceptance of even small gifts has been documented to affect clinical judgment and heightens the perception (as well as the reality) of a conflict of interest." [1]

The American Medical Association (AMA) wrote guidelines in 1990 that are similar to those just reissued this past summer. The Pharmaceutical Research and Manufacturers of America (PhRMA) also adopted the guidelines. Compliance with the guidelines lapsed with time (big surprise there, huh?) as the gifts became more substantial. [2]

Find the recently updated AMA document at

www.ama-assn.org/ama/pub/category/5689.html

The primary points are below:

> "To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function.

2. Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads).

3. The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented.

4. Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

5. Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time.

6. Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution.

7. No gifts should be accepted if there are strings attached." [3]

Be aware that 9 major pharmaceutical companies as well as the AMA sponsored the above-mentioned work group.

The American College of Clinical Pharmacy wrote a position statement in 1993. The seven guidelines in the statement are as follows: [4]

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Pharmacists and the pharmaceutical industry should collaborate in efforts to optimize patient care.

- Pharmacists should place the welfare of patients paramount in pharmacotherapeutic decisions.
- Pharmacists should not solicit or accept gifts that might influence or appear to influence objectivity or clinical judgment.
- Pharmacists should avoid financial, consulting, or other relationships that are or appear to constitute conflicts of interest.
- Pharmacists participating in educational programs or preparing written materials on drug therapy should deliver fair and unbiased presentations.
- Pharmacists should participate only in research that meets accepted standards for scholarship and will influence pharmacotherapy positively.
- Lectures or classes on professional ethics should be incorporated into the curricula of colleges of pharmacy, residency, and fellowship training programs, and continuing education programs.

And of course, the Services have their regulations concerning acceptance of gifts too. Army Regulation 1-100 (Gifts and Donations) and Army Regulation 1-101 (Gifts for Distribution to Individuals), as a well as Title 31 U.S.C. Code 1353, prescribes procedures for the acceptance of travel benefits from non-federal sources. (I had this source in my files. If you want the Air Force and Navy ones, you're on your own looking for them, but I'll bet they're similar.)

As mentioned in the last article, the Department of Health and Human Services just placed a document in the Federal Register for 60 days of comment. It can be viewed at **http://oig.hhs.gov/fraud/docs/complianceguidance/draftcpgpharm09272002.pdf**. It should be noted that this is directed at the pharmaceutical industry, not at providers and pharmacists. One also notes early on in the document that compliance is voluntary.

So what about evidence?

Well, there have been a number of studies on these issues, but they are not, of course, the randomized, double-blinded, placebo-controlled trials that we typically think of. These are observational and/or survey/database reviews (as you might expect).

Rationalization #1

I'm not influenced by a piece of pizza or a pen in my prescribing practices.

What I found:

Numerous studies appear to show otherwise. A meta-analysis was performed to evaluate relationships between physicians and industry, attitudes involved, and impact of the contacts on behavior. Of 538 studies, 29 were suitable for analysis. Results revealed the following:

- "Physician interactions with pharmaceutical representatives were generally endorsed, began in medical school, and continued at the rate of about 4 times per month.
- Meetings with pharmaceutical representatives were associated with requests by physicians for adding the drugs to the hospital formulary and changes in prescribing practice.
- Drug company-sponsored continuing medical education (CME) preferentially highlighted the sponsor's drug(s) compared with other CME programs. Attending sponsored CME events and accepting funding for travel or lodging for educational symposia were associated with increased prescription rates of the sponsor's medication.
- Attending presentations given by pharmaceutical representative speakers was also associated with nonrational prescribing." [5]

Interestingly, Dr. Wazana's meta-analysis also mentions a study of medical students and their attitudes of gift acceptance. 85% of the students felt it was improper for politicians to accept a gift, but only 46% of the students thought it a problem if they were to accept a gift similar in value from a pharmaceutical company. [6] (But I doubt I'd ever get offered a gift of similar value, anyway.)

Rationalization #2

These trinkets don't cost that much anyway. What's the fuss about? Buzz off, Barb.

What I found:

The dollar figures involved in 2000 have been estimated at $15.9 billion per

year for promotion and marketing by the pharmaceutical industry, with about a third of that going to sales representatives for their use. This breaks down further to $8000 - $13,000 spent per year on **each physician**. [7] [8] [9] They're not spending the bucks on you because of your magnetic personality. They wouldn't be forking this many greenbacks out, if a change in a majority of physicians' prescribing behavior could not be effected. Industry spends money when a return on investment can be demonstrated. The cost of that gift you accept is passed on to the patient. [10]

Rationalization #3

My favorite personal fallacy (I say this all the time over here at the PEC):
"I never remember what company makes which product so I won't be influenced."

What I found:

Studies have looked at that excuse, too. Residents surveyed were correct in that they did not remember which company made which drug; but, they remembered that the reps that gave them some type of gift were also the reps they felt provided them with the most useful information. [11] Much of that information is very useful, **if** it is presented accurately. That is when the pharmaceutical reps can be a lifesaver for docs who don't have the time to keep up with all the journal information that's out there (that would be, hmm, **ALL** of us). The problem here is illustrated by several studies that have been done in the past few years looking at the accuracy of information obtained from drug reps. A 1995 JAMA article, [12] demonstrated that of 106 statements made by pharmaceutical reps during 13 presentations, 11% were found to be inaccurate (contradicted material in the package insert or handed out by the company). All inaccurate statements were favorable to the drug being promoted. When surveying the physicians who attended these presentations, only 26% recalled hearing any false or inaccurate statements. A similar study was published in the past year in The Lancet.

I know I've included this reference before, but it's worth looking at again. To help you evaluate a presentation from a pharmaceutical representative, use the checklists developed by Drs. Slawson and Shaughnessy of UVa entitled Obtaining Useful Information from Pharmaceutical Representatives at **www.med.virginia.edu/ed-programs/cme/ebm/files/drugrep02revised.ppt**. It will be available until the next conference in April 2003.

Rationalization #4

Well, my patients aren't going to care about what gifts I get from industry.

What I found:

Several studies have looked at this issue with consistent results. Patients **DO** care. Patients perceived gifts as more influential and less appropriate than the physicians who were surveyed. One of these studies was done at Walter Reed. [13] Another survey presented an array of gifts for patients to comment on. The perception of most patients was that gifts influence the prescribing pattern and increase the cost of medications, with the exception of drug samples. Patients did not approve of physician gifts, even of little value, if they were of little to no benefit to the patient. [14] None of these studies are randomized-controlled trials, but that probably really doesn't matter. Perception drives everything.

What about CME and pharmaceutical sponsorship? It's too big a topic for this article, but, borrowing from an article in the Canadian Medical Association Journal, it would be beneficial to ensure that you've truly chosen to attend Continuing Medical *Education* and not Continuing Medical *Entertainment*. [15]

The Bottomline

So, should physicians and pharmacists avoid any and all contact with industry? Of course not. We need each other, as do our patients. Common sense just needs to guide **both** sides in what is offered and what is accepted, in addition to acknowledging the fact that we are **ALL** influenced in some way by everyone we have contact with. No one is immune. Neither are we alone. "On March 20, (2001) by a vote of 74 to 25, the Senate killed an amendment that would have barred congressmen and congressional candidates from accepting contributions from registered lobbyists while Congress is in session." [16] You already know what medical students think about that.

Just for Fun

I'll leave you with a few advertising quotes I found on the web, courtesy of the Department of Advertising, The University of Texas at Austin **(http://advertising.utexas.edu/research/quotes/Q100.html#Advis).**

- "[A]dvertising is a symbol-manipulating occupation." - S.I. Hayakawa
- "Advertising – a judicious mixture of flattery and threats." - Northrop Frye
- "Advertising may be described as the science of arresting the human intelligence long enough to get money from it." - Stephen Butler Leacock

- Advertising is "[a] ten billion dollar a year misunderstanding with the public." - Chester L. Posey
- "Advertising is the 'wonder' in Wonder Bread." - Jef I. Richards
- "Advertising is the modern substitute for argument; its function is to make the worse appear the better." - George Santayana
- "We find that advertising works the way the grass grows. You can never see it, but every week you have to mow the lawn." - Andy Tarshis
- If advertising was that powerful, then people would believe there's talking fruit in their underwear." - Dick Sittig
- "This war will not be over by the next commercial break." - US spokesperson talking to reporters during the Gulf War
- "Wining, dining, and pocket lining." - Anonymous

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[1] American College of Physicians. Ethics Manual. Fourth Edition. Annals of Internal Medicine. 1998;128:576-594. www.acponline.org/journals/annals/01/apr98/ethicman.htm

[2] Robeznieks, Andis, Pharmacy group details what drug reps can give physicians. AMNews. May 27, 2002. www.ama-assn.org/sci-pubs/amnews/pick_02/prl10527.htm

[3] American Medical Association. E-8.061 Gifts to Physicians From Industry. www.ama-assn.org/ama/pub/category/5689.html

[4] ACCP. ACCP Position Statement. Pharmacists and the Pharmaceutical Industry: Guidelines for Ethical Interactions. Pharmacotherapy 1993;13(5):531-533.

[5] Wazana, Ashley MD. Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift? JAMA Vol 283(3);19 January 2000:373-380.

[6] Palmisano P, Edelstein J. Teaching drug promotion abuses to health profession students. J Med Educ. 1980;55:453-455.

[7] Ibid Wazana.

[8] Ebell, Mark. Pharmaceutical freebies. Family Practice Management. Vol 9(8) September 2002.

[9] Angell, Marcia and Arnold S. Relman. Prescription for Profit. The Washington Post. June 20, 2001; p A27.

[10] Chren, MM. Landefeld CS. Murray TH. Doctors, drug companies, and gifts. JAMA. 1990 Apr 25;263(16):2177-9.

[11] Wazana, Ashley and Francois Primeau MD, FRCP. Ethical considerations in the relationship between physicians and the pharmaceutical industry. Psychiatric Clinics of North America. Vol 25(3); Sept 2002.

[12] Ziegler, MG et al. The accuracy of drug information from pharmaceutical sales representatives. JAMA. 1995 Apr 26;273(16):1296-8.

[13] Gibbons RV, et al. A comparison of physicians' and patients' attitudes toward pharmaceutical industry gifts. J Gen Intern Med 1998 Mar;13(3):151-4.

[14] Blake, Robert L Jr. MD; Early, Elizabeth K. Patients' Attitudes About Gifts To Physicians From Pharmaceutical Companies. The Journal of the American Board of Family Practice. Vol8(6) Nov/Dec 1995: pp 457-464.

[15] Sullivan, Patrick. Freebies to MDs targeted as drug industry starts publicizing CME fines. CMAJ Sept 19, 2000; 163(6): 749-a.

[16] Human Events Online. Senate Welcomes Lobbyist Gifts During Session. The National Conservative Weekly. The Week of April 2, 2001. www.humaneventsonline.com/articles/04-02-01/sv2.html

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2003 DoD Pharmacoeconomics & Pharmacy Benefit Conference

The 2003 DoD Pharmacoeconomics & Pharmacy Benefit Conference will be held January 12 - 15, 2003, at the St. Anthony Hotel in San Antonio, Texas. The theme for the 2003 conference, which is sponsored by the University of Texas, is "Measuring the Clinical Outcomes of Drug Therapy." The conference is recommended for physicians, pharmacists, and nurses interested in measuring and improving clinical outcomes of drug therapy. Speakers from DoD and the VA will discuss the concepts of outcomes measurement with emphasis on the practical application of these concepts to MTF situations.

The agenda and registration forms for the conference are now available on the PEC website at **www.pec.ha.osd.mil/2003_PEC_Conference/PEC_conference_2003.htm**.

Highlights from the agenda:

- Evidence Based Medicine - Clinical Process Improvement
- Overview of VA Drug Outcomes Research Program
- Basic Concepts of Outcomes Measurement and Pharmacoepidemiology
- Measuring Patient Outcomes Workshop
- Designing Practical Outcome Measures - Using DoD Data Sources
- Understanding and Preventing Adverse Drug Reactions - Therapeutic and Process Applications
- Research Funding Opportunities in DoD

Questions may be directed to **COL Doreen Lounsbery** or **Dr. Eugene Moore** at the DoD Pharmacoeconomic Center, 210-295-1271 (DSN prefix 421-). The **registration form** for the

conference should be mailed or faxed to Jill Williams at the University of Texas at Austin College of Pharmacy at the address/fax number on the form. The registration deadline has been extended until 13 Dec 2003.

The Department of Defense Pharmacoeconomic Center
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New Drug Watch

Angela Allerman
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DoD Pharmacoeconomic Center

Several of the drugs discussed at the November 2002 DoD P&T Committee were reviewed in the October issue of the *PEC Update*; the remainder are found below, along with some additional drugs recently approved by the FDA and the usual assortment of odds-and-ends and pharmaceutical news.

Quick Links

Newly Approved Drugs From Head to Toe

Neurology / Psychiatry

In spite of its generic name, **aripiprazole (Abilify; BMS)** is not a proton pump inhibitor, but a new atypical antipsychotic for the treatment of schizophrenia. Unlike other atypical antipsychotics (e.g., olanzapine, risperidone, ziprasidone, quetiapine), which are D2 and 5-HT2 receptor antagonists, aripiprazole is a partial D2 and 5-HT1A receptor agonist and a 5-HT2A receptor antagonist. Marketing will focus on differences in adverse reaction profile vs. other atypical antipsychotic agents. The incidence of EKG changes with aripiprazole appears similar to placebo.

Immunology / Oncology

PEG interferon alfa-2a (Pegasys; Roche) is the second pegylated interferon (IFN) to reach the market. Addition of a polyethylene glycol (PEG) side chain decreases IFN clearance, allowing for once weekly dosing instead of three times weekly administration. PEG-interferon alfa-2a is indicated for treating adults with hepatitis C who have compensated liver disease and who have not been previously treated with interferon alfa. An indication for use in

combination with ribavirin was recommended for approval by an FDA advisory committee on 15 Nov 02. June 2002 Guidelines from the NIH for treating hepatitis C state the standard of care is a pegylated interferon in combination with ribavirin. Schering already has a pegylated interferon product, PEG Intron (PEG interferon alfa-2b), on the market. Roche does not anticipate shortages of the Pegasys product; no patient waiting list or sign-up program is required. As a side note, Schering's enrollment program for PEG-Intron has been discontinued.

Endocrinology

Glipizide / metformin tablets (Metaglip; BMS) are indicated for use in type 2 diabetics as an adjunct to diet and exercise in patients not adequately controlled with diet and exercise alone. It is also approved for type 2 diabetics who are not achieving adequate glycemic control with metformin or a sulfonylurea. The product is targeted for use by providers who prefer glipizide over glyburide (a glyburide/metformin combination [Glucovance; BMS] is already available). Another new metformin combination, rosiglitazone/metformin (Avandamet; GSK), was mentioned in October's New Drug Watch column.

Cardiology

Ezetimibe (Zetia; Merck/Schering Plough) is a cholesterol absorption inhibitor indicated for use as monotherapy and in combination with a statin in primary hypercholesterolemia and for two rare hereditary lipid disorders. The approved dosage is 10 mg daily. Ezetimibe lowers LDL levels by 18% when administered as monotherapy. When used in combination with 20 mg simvastatin, LDL lowering effects are similar to 80 mg of simvastatin administered alone (46% LDL reduction vs 45%). The marketing campaign will focus on the concept of using ezetimibe in combination with lower statin doses, potentially lowering the risk of rhabdomyolosis. LFT monitoring requirements are the same for the combination of ezetimibe plus a statin as for a statin alone.

Adding ezetimibe to a statin does not appear to result in the same incremental lowering of LDL at higher statin doses: ezetimibe plus simvastatin 80 mg reduces LDL by about 58%. The FSS price of ezetimibe as of 15 Nov 02 is $1.44/day; the combination of ezetimibe and simvastatin 20 mg would cost about $2.00 per day vs. $0.89 for simvastatin 80 mg.

Infectious Disease

Nitazoxanide oral suspension (Alinia; Romark Labs) is an anti-protozoal agent indicated for treating diarrhea caused by *Cryptosporidium parvum* and *Giardia lamblia* in pediatric patients (aged 1-11 years). It was previously available on a compassionate basis for cryptosporidial diarrhea

associated with AIDS, but the company did not pursue further studies recommended by the FDA for this indication. Nitazoxanide was given a priority review by the FDA for pediatric patients. Labeling states that safety and efficacy have not been established for AIDS patients, or for adults. Clinical trials in pediatric patients were conducted in Egypt, Zambia, and Peru.

New OTC Meds

- **Nicotine polacrilex lozenges (Commit)** were approved 31 Oct 02 to aid adults in reducing withdrawal symptoms and cravings associated with smoking cessation. The lozenges are available in 2 and 4 mgs and have a mint flavor. If the "Time to First Cigarette" (TTFC) is within 30 minutes of awakening, then the 4 mg lozenge should be used; if the TTFC is after 30 minutes of awakening, then the 2 mg lozenge should be used. The recommended treatment course is 12 weeks. The estimated retail cost of 72 lozenges is approximately $40.00.

Loratadine (Claritin; Schering Plough) received FDA approval for OTC use on 27 Nov 02. OTC product labeling for loratadine is currently limited to seasonal allergic rhinitis, although an application for chronic urticaria has been submitted to the FDA. All dosage formulations of loratadine will go OTC (tablets, orally disintegrating tablets [Redi-tabs], syrup, and loratadine/pseudoephedrine 12- and 24-hour extended release tablets). Availability of the OTC product is expected in mid-December, after which no further prescription product will be available.

The patent for Claritin is set to expire 19 Dec 2003. Applications for generic loratadine products are pending from multiple companies; the generics are expected to be OTC.

A potential Rx-to-OTC switch for fexofenadine (Allegra; Aventis) and cetirizine (Zyrtec; Pfizer) is under FDA review. It is unclear whether such a switch will actually occur.

- **Guaifenesin 600 mg extended release tablets (Mucinex; Adams Labs)** have received FDA approval as an OTC product. The approval represents the first time extended release guaifenesin will be available under an NDA; it also triggers provisions of the 1951 Durham-Humphrey amendment that forbid simultaneous marketing of OTC and prescription versions of products of the same strength, dose, and indication for use. For more background, please the sidebar for LT Chad McKenzie's

Impact of Mucinex on the DoD Pharmacy Benefit

LT Chad McKenzie, MSC, USN

Guaifenesin has an established record of safety and effectiveness as an expectorant under the OTC monograph system, established under the Kefauver-Harris Amendments of 1962 to the Food, Drug, and Cosmetic Act (FDCA). Consequently, oral guaifenesin products were available to U.S. consumers without formal submission of a

excellent & succinct summary.

New Indications

- The combination of **rabeprazole (Aciphex; Janssen),** amoxicillin, and clarithromycin is now indicated for *Helicobacter pylori* eradication to reduce the risk of duodenal ulcer recurrence. The dosage is as follows: rabeprazole 20 mg bid + amoxicillin 1000 mg bid + clarithromycin 500 mg bid, all for 7 days.

- On 28 Oct 02, both **simvastatin (Zocor; Merck)** and **atorvastatin (Lipitor; Pfizer)** received FDA approval for treating familial hypercholesterolemia in boys and girls (at least one year postmenarchal) aged 10 to 17 years. The simvastatin dose for adolescents is 10-40 mg qd, while the atorvastatin dose is 10-20 mg qd.

- **Pravastatin (Pravachol; BMS)** also received a pediatric indication for familial hypercholesterolemia in children on 18 Nov 02, however, pravastatin is approved for children 8-13 years of age (20 mg qd) and 14-18 years of age (40 mg qd). The new pediatric labeling extends marketing exclusivity for Pravachol for an additional 6 months, until April 2003.

  Cetirizine (Zyrtec; Pfizer) is now approved for treating perennial allergic rhinitis and chronic idiopathic urticaria in children down to 6 months of age. It was previously approved down to age 2.

  Levofloxacin (Levaquin; J&J) is now indicated to treat nosocomial pneumonia.

New Generics

New Drug Application (NDA). However, the OTC monograph system does not include provisions for extended release dosage form drug products, and the FDA has determined that single ingredient guaifenesin extended release drug products are new drugs and require an approved application for marketing.

As of July 12, 2002, Adams Pharmaceuticals received FDA approval of their NDA for single ingredient guaifenesin extended release product (Mucinex) as an OTC product. Previously, all single ingredient guaifenesin extended release products were available by prescription only. Under the Durham-Humphrey Amendment of 1951 to the FDCA, no manufacturer can market single ingredient guaifenesin extended release products as legend drugs since Mucinex has been approved as an OTC product. The Durham-Humphrey Amendment forbids simultaneous marketing of products of the same strength, dose, and indication for both OTC and prescription use.

Following approval of Mucinex as the only single ingredient guaifenesin extended release product, all other currently marketed single ingredient guaifenesin extended release products are considered misbranded and in violation of section 505(a) of the FDCA. The FDA has sent warning letters to all manufacturers and distributors of single ingredient guaifenesin extended release products at the beginning of October requesting action plans to bring their products into compliance with Section 505 of the FDCA. In these letters, the FDA stated "If appropriate corrective action is not undertaken, the FDA may initiate legal action without further notice." At least one affected manufacturer is known

to be petitioning this action, therefore it is unknown at this time if all single ingredient guaifenesin extended release products without a currently approved NDA will be withdrawn from the market.

Mucinex is available as a 600-milligram single ingredient guaifenesin extended release product, with a labeled maximum dosage of 2400mg per day taken as 1-2 tablets every 12 hours. The product is approved for use in patients of age 12 and older. The manufacturer of Mucinex conducted bioequivalency studies but no new efficacy studies; efficacy data was drawn from previous studies used for approval of the existing OTC monograph for guaifenesin.

- Barr is launching two new generic **progestin-only oral contraceptive formulations.** The A-rated Barr generic for Watson's Nor-QD will be Camilla, and the A-rated generic for Ortho's Micronor will be Errin. Both products contain 0.35 mg of norethindrone. Nor-QD and Micronor are not generically equivalent to each other.

- **Isotretinoin soft-gelatin capsules (Amnesteem; Bertek)** will be marketed in 10-, 20- and 40 mg strengths. This product is bioequivalent to Roche's Accutane. The product will have to follow the same risk management requirements as Accutane.

- Teva and Ranbaxy have obtained FDA approval to market generic formulations of **amoxicillin/clavulanate** in the 875 mg/125 mg strength. Geneva has also marketed a generic amoxicillin/clavulanate product, however, manufacturing capacity has not been sufficient to met demand.

New Lab Tests

- **N-terminal pro-B-type natriuretic peptide [NT-proBNP], (Elecsys proBNP Immunoassay, Roche Diagnostics)** has been approved by the FDA to aid in diagnosing congestive heart failure. In CHF, natriuretic peptide levels increase with worsening CHF and increased cardiac volume and left ventricular pressure. This automated test detects the levels of NT-proBNP - the higher the blood level, the more serious the condition. Test results are available in approximately 18 minutes.

New Medical Devices

- A defibrillator specifically designed for use in the home has been approved by the FDA. Philips Electronics will market the **HeartStart Defibrillator** at a cost of approximately $2300. A prescription is required.

New Precautions, Warnings & Labeling Changes

- **Valdecoxib (Bextra; Pharmacia)** has new warnings regarding reports of serious skin reactions, including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis occurring in post-marketing surveillance studies. Anaphylactoid reactions and angioedema have also been reported. Labeling has also been changed to state that valdecoxib is

contraindicated in patients allergic to sulfa containing products. Valdecoxib should be discontinued at the first sign of skin rash or other hypersensitivity. The FDA "Talk Paper" can be accessed at **www.fda.gov/bbs/topics/ANSWERS/2002/ANS01170.html**.

- **Ergotamine tartrate and caffeine suppositories (Cafergot; Novartis)** now carry a black box warning stating that co-administration with potent CYP 3A4 inhibitors (e.g., protease inhibitors and macrolide antibiotics) is contraindicated. Serious / life-threatening peripheral ischemia has been reported. The risk of vasospasm leading to peripheral / cerebral ischemia is increased due to CYP inhibition causing elevated blood levels of ergotamine / caffeine.

- Concomitant use of **sertraline (Zoloft; Pfizer)** with **pimozide** is contraindicated. A pharmacokinetic study showed that co-administration of sertraline 200 mg with pimozide 2 mg increased pimozide AUC and Cmax 40%, but EKG changes were not reported. Since pimozide is a narrow therapeutic index drug and the interaction occurred at a low pimozide dosage, the concurrent use of these two drugs is not recommended.

New Guidelines

- **Stable Angina:** New guidelines for the management of patients with chronic stable angina were released by the American College of Cardiology. Full publication will not occur until the 1 Jan 03 issue of the Journal of the American College of Cardiology and the 7/14 Jan 03 issue of Circulation. The previous update occurred in 1999. The full guideline is published on the American College of Cardiology website at **www.acc.org/clinical/guidelines/stable/stable.pdf**.

- **GERD:** The American Gastroenterology Association has released an evidence-based consensus statement for managing GERD. Download the summary at **www.gastro.org/public/media/newsreleases/GERD-Nov02.html**, and the full report at **www.gastro.org/phys-sci/edu-cme/GERDmonograph.pdf**.

- **Irritable Bowel Syndrome:** Evidence-based guidelines for treating irritable bowel syndrome have been published by the American College of Gastroenterology as a supplement to the *American Journal of Gastroenterology* in November, 2002; 97 (11 Suppl): S1-26. The summary position statement can be found at **http://download.medicinedirect.com/pdfs/journals/0002-9270/PIIS0002927002056563.pdf**, and the full guidelines at **http://download.medicinedirect.com/pdfs/journals/0002-9270/PIIS0002927002056575.pdf**. Registration (free) is required to access the site.

- **Primary prevention of hypertension:** The National High Blood Pressure Education Program (NHBPEP) has updated its recommendations for the primary prevention of hypertension, which were first released in 1993. Six factors have been found to help, and they are similar to what Mom told you: engage in physical activity, maintain a normal body weight, limit alcohol consumption, reduce sodium intake, maintain adequate potassium intake, and eat your fruit and veggies, while reducing saturated and total fat. The article is published in JAMA Oct 16 2002;288:1882-88. The abstract and information about reprints is available at **http://jama.ama-**

assn.org/issues/v288n15/abs/jsc20296.html.

Upcoming Study Results

- In Mid-December look for the results of **ALLHAT** (**A**ntihypertensive and **L**ipid **L**owering treatment to prevent **H**eart **A**ttack **T**rial), to be published in JAMA. This trial is one of the largest hypertension trials ever conducted, enrolling over 40,000 patients into 4 treatment arms: amlodipine, doxazosin, lisinopril, and chlorthalidone. The doxazosin arm was prematurely discontinued due to an excessive incidence of congestive heart failure compared to chlorthalidone. ALLHAT results are eagerly anticipated, as JNC-VII has been delayed pending the completion of this trial.

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PDTS Corner

Update on the Pharmacy Data Transaction Service

Quick Links

PDTS One of Seven Finalists for the 2002 President's Quality Award

Ceremony held at the Ronald Reagan Center, Monday 25 November 2002

The Pharmacy Data Transaction Service (PDTS) was honored at a 25 Nov 2002 ceremony in Washington, D.C., as one of seven finalists for the 2002 President's Quality Award, selected from among 100 applications. Representatives from the CSSC and WebMD were in attendance.

Comments about PDTS from the nomination & ceremony materials:

> The mission of the Military Health System, under the Assistant Secretary of Defense for Health Affairs, is to enhance the Department of Defense (DoD) and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care. Currently, 8.7 million beneficiaries are eligible for DoD health benefits through TRICARE. The TRICARE Management Activity recognized that patients who utilized pharmacy services in the Military Health System were exposed to unnecessary safety risks because the databases of its three dispensing points—110 Composite Health Care System HOST sites in Direct Care, over 40,000 civilian TRICARE retail networks, and mail order—were not integrated. Consequently, patients' complete medication histories were not available to enable identification of potential life-threatening drug interactions.
>
> In response to this potential life-threatening problem, the TRICARE Management Activity developed the Pharmacy Data Transaction Service (PDTS), which creates a central data

repository that records information about prescriptions filled for DoD beneficiaries through any of the three Points of Service mentioned above. The immediate objective of implementing the integrated system was to improve the quality of care provided to beneficiaries by reducing their risk to adverse drug interactions and therapeutic duplications. The strategic objective was to provide enhanced pharmacy benefit programs to the beneficiary population while reducing overall program costs.

The integrated system requires all health care system points of service to electronically transmit selected patient and drug information to the pharmacy claims manager. The average complete transaction time, from prescription order entry to encrypted transaction response, is 3.1 seconds for sites located within the United States and 3.8 seconds for sites outside of the United States. The fact that the system performs the clinical drug screenings on-line in real time without disrupting patient care, has been a major factor in its success. The potential vulnerabilities of an Internet-based system are virtually eliminated through the use of the most current electronic technology. To safeguard the privacy of beneficiary information, all stored historical pharmacy data and transactions are encrypted to meet the privacy and security standards required by the 1996 Health Insurance Portability and Accountability Act.

The system is currently used at approximately 350 direct care Military Treatment Facilities (MTF) worldwide, with more than 700 dispensing pharmacies, and 40,000 individual providers using on-line order entry. Since activation in December 2000, the system has processed more than 113 million prescription transactions and the Prospective Drug Utilization Review function had identified more than 52,700 potentially life-threatening drug interactions.

The new integrated system is a great success. It provides a critical tool for delivering a quality pharmacy benefit now, as well as historical data to develop future policies, procedures, and programs that will further enhance the pharmacy benefit.

Thanks go out to all that were and are an important part of the development, implementation, and sustainment of PDTS!

PDTS selected as one of 17 results-driven federal government programs as a semifinalist for Harvard's Innovations in American Government Award

PDTS has been selected as one of 17 results-driven federal government programs to be a semifinalist for Harvard's prestigious Innovations in American Government Award. The 17 programs are among 99 semifinalists selected from a pool of nearly 1,000 applicants. Fifteen of the 99 semifinalists will be named as finalists by the end of this year.

The CSSC at Combined Forces

By COL (Ret) Roger Williams, PDTS CSSC Clinical Support Supervisor

To DoD Pharmacy Personnel:

As always, it was wonderful to see everyone again at the Combined Forces Pharmacy Seminar and even meet some new folks. We wish everyone could have attended but we know some have to stay behind to cover the store. We appreciate your attendance at our Business Objects Demo and everyone who took the time to come by the booth and see us. The PowerPoint slides from the CSSC's Combined Forces presentation, "Pharmacy Data Transaction Service Update", are available on the PEC Website at **www.pec.ha.osd.mil/Com_Forces_Sem/CFPS.htm**.

Don't forget to contact us to set-up your Business Objects Training session! More information at **www.pec.ha.osd.mil/PDTS/pdts_busobj_new.htm**.

Editor's Note: Congratulations to COL Williams for his excellent poster, "PDTS: A Vital Tenet in DoD Pharmacy's Support of Patient Safety, Readiness and Homeland Defense," which won the "Poster Best Representing Conference Theme" award at Combined Forces!

Defenselink News Releases

(22 Nov 02): **Pharmacy Data Transaction Service Awarded Twice for Enhancing Patient Safety**

(25 Nov 02): **Federal Agencies Honored at President's Quality Award Ceremony**

Data Integrity for the Holidays...

As a special treat: not one word about data integrity! See you in January!

Top 10 Level 1 Drug-Drug Interactions by Point of Service

By COL (Ret) Roger Williams, PDTS CSSC Clinical Support Supervisor

The feature in PDTS that enhances patient safety is the process of conducting Prospective Drug Utilization Reviews (ProDURs). PDTS conducts on-line ProDURs (clinical screens) on all medications dispensed, regardless of the DoD point of service the patient used to have the prescription filled. Pharmacy personnel need to be aware that with the activation of PDTS, the number of clinical screenings could increase depending on how frequently patients use multiple prescription sources. PDTS clinical screens are performed only on those medications the patient obtains from outside of the dispensing site's host cluster. It will not duplicate clinical warnings generated from within the CHCS host system.

For further information about the PDTS DURs, see **my article in the Mar 2002 PEC Update**.

Top 10 Potential Level 1 Drug-Drug Interactions in MTFs, September 2002

Rank	Medications involved	#

1	Ibuprofen / Ketorolac tromethamine	331
2	Ketorolac tromethamine / Naproxen	151
3	Nitroglycerin / Sildenafil citrate	86
4	Ketorolac tromethamine / Rofecoxib	65
5	Celecoxib / Ketorolac tromethamine	59
6	Isotretinoin / Minocycline HCl	56
7	Aspirin / Ketorolac tromethamine	34
8	Doxycycline hyclate/ Isotretinoin	33
9	Ketoconazole / Simvastatin	33
10	Itraconazole / Simvastatin	26

Top 10 Potential Level 1 Drug-Drug Interactions in the Retail Network, September 2002

Rank	Medications involved	#
1	Ibuprofen / Ketorolac tromethamine	118
2	Nitroglycerin / Sildenafil citrate	93
3	Ketorolac tromethamine / Naproxen	73
4	Celecoxib / Ketorolac tromethamine	69
5	Isotretinoin / Minocycline HCl	65
6	Ketorolac tromethamine / Rofecoxib	60
7	Ketoconazole / Simvastatin	48
8	Entacapone / Selegiline HCl	48
9	Isotretinoin / Doxycycline Hyclate	33

10	Ketorolac tromethamine / Valdecoxib	27

Top 10 Potential Level 1 Drug-Drug Interactions in Mail Order, September 2002

Rank	Medications involved	#
1	Nitroglycerin / Sildenafil citrate	83
2	Ketoconazole / Simvastatin	18
3	Intraconazole / Simvastatin	13
4	Ketorolac tromethamine / Rofecoxib	12
5	Amiodarone HCl / Gatifloxacin	9
6	Celecoxib / Ketorolac tromethamine	9
7	Sildenafil / Isosorbide mononitrate	8
8	Amiodarone / Moxifloxacin	7
9	Sotalol/ Moxifloxacin	7
10	Entacapone / Selegiline	7

The PDTS Customer Service Support Center

The PDTS CSSC strives to provide world-class customer support to all Military Health System users while enhancing the operational effectiveness and ensuring the quality of information maintained within the Pharmacy Data Transaction Service. The PDTS CSSC comprises the Pharmacy Benefit Operations Division of the PEC and is co-located with the Clinical Operations Division of the PEC at Ft. Sam Houston, TX.

The PDTS CSSC has an e-mail address for questions, comments, concerns, or report requests:

PDTS@cen.amedd.army.mil

Drop us an e-mail! We will respond via e-mail or call you within 1 business day.

Or call the PDTS CSSC at:

- **DSN: 471-8274**
- **Toll-free commercial:**
  1-866-275-4732
  (1-866-ASK4PEC)
- **Local commercial (San Antonio):**
  (210) 221-8274
- **OCONUS:**
  (AT&T access code)+866-275-4732

Need more information?

Many materials pertaining to PDTS, including trouble call procedures, the PDTS Report Request Form, business rules, and interchange control documents (ICDs), are available in the PDTS section of the PEC website. Just go to www.pec.ha.osd.mil/pdts/pdts_documents.htm and browse through the options on the left-hand navigation bar.

In addition, many articles on various aspects of PDTS and the PDTS CSSC have been published in recent issues of the PEC Update. Please visit the PEC Update page on the PEC website - www.pec.ha.osd.mil/ac03000.htm - for back issues.

We are here to serve you 24 Hours a Day, 7 days a Week.